UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

ANGELA DIGREGORIO, Plaintiff,	)	
	)	CIVIL ACTION NO.
v.	)	03-11191-DPW
PRICEWATERHOUSE COOPERS LONG TERM DISABILITY PLAN, and HARTFORD COMPREHENSIVE EMPLOYEE BENEFIT SERVICE COMPANY, Defendants.	)	

MEMORANDUM AND ORDER
August 9, 2004

Plaintiff Angela DiGregorio brings this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Specifically, DiGregorio seeks, pursuant to 29 U.S.C. § 1132(a)(1)(B), review of the decision by defendant Hartford Comprehensive Employee Benefit Service Company ("Hartford") to discontinue the disbursement of long term disability ("LTD") benefits by her former employer. DiGregorio has moved for judgment on the administrative record, and defendants have cross-moved for summary judgment. With the agreement of the parties, I treat the cross-motions as a case stated. For the reasons set forth below, I will grant judgment for the defendants.

I. BACKGROUND

A. Facts

1. DiGregorio's Claim for LTD Benefits

Except where noted, the following facts are not disputed by the parties.

Plaintiff Angela DiGregorio worked as a secretary for Coopers & Lybrand ("Coopers"), the corporate predecessor to PricewaterhouseCoopers, from September 1988 through February 2, 1995.[1] Administrative Record ("AR"), at 396. She stopped work after February 2, 1995 and began receiving workers' compensation benefits the following day. Id. Several months later, DiGregorio submitted a claim form for LTD benefits, dated July 12, 1995, to Pacific Mutual Life Insurance Company ("Pacific Mutual"), which administered what was then the Coopers & Lybrand Employee Long Term Disability and Income Plan and is presently defendant PricewaterhouseCoopers Long Term Disability Plan (collectively the "Plan").

In the claim form, DiGregorio indicated that she was experiencing "numbness in [her] fingers with constant tingling" which began in March of 1989 and was caused by the "cumulative trauma—-repetitive work" in her job at Coopers. Id. In a section of the claim form filled out by Dr. John Walsh,

[1]In the LTD benefits claim form that DiGregorio filled out in July of 1995, she wrote that her last day of work was on February 2, 1994, but this seems to be a clerical error because the remainder of the form, including the part filled out by Coopers, indicates that she stopped working after February 2, 1995. AR, at 306.

DiGregorio's attending physician, Dr. Walsh wrote that he had last examined DiGregorio on June 1, 1995 and that he had diagnosed her with "bilateral carpal tunnel syndrome." Id. at 397. Under the heading "Physical Impairment," Dr. Walsh circled "Class 5," which indicated "Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)," and under the heading "Prognosis," he indicated that DiGregorio was "totally disabled" for her job. Id. He further noted that it was unknown when she would recover sufficiently to perform her duties. Under "Remarks," Dr. Walsh wrote: "Pt remains disabled." Id.

Under the Plan an employee is initially entitled to LTD benefits if the employee cannot perform the duties of the employee's own particular occupation. Thus, the Plan's definition of "Total Disability," begins with what the parties here refer to as the "own occupation" provision:

> A disability which wholly and continuously disables the employee so that he can perform no duty pertaining to his occupation and during which he is not engaged in any occupation for remuneration or profit.

Id. at 22 (emphasis added). To receive LTD benefits for a period of more than two years under the Plan, however, the employee must be unable to perform not only the employee's own occupation but any occupation for which the employee is qualified. To this end, the Plan contains the following "any occupation" provision:

> [A]fter an income has been payable under the PLAN for 24 months during any one period of disability, it shall not then and thereafter constitute TOTAL DISABILITY unless during its further continuance it shall also

> wholly and continuously disabled [sic] the employee so that he can perform no duty pertaining not only to his occupation but to any occupation for remuneration or profit for which he is, or may be, qualified by education, training or expertise. In no event, however, shall TOTAL DISABILITY be deemed to exist for any period during which the employee is not under the regular care of a PHYSICIAN, other than himself or a member of his immediate family.

Id. at 22 (emphasis added).

By letter dated September 25, 1995, Pacific Mutual approved DiGregorio's claim for LTD benefits, and DiGregorio began receiving LTD benefits under the "own occupation" provision of the Plan effective August 1, 1995. Id. at 308; Plaintiff's Statement of Facts ¶¶ 17-18; Defendants' Statement of Facts ¶ 17. In a letter dated June 2, 1997, Pacific Mutual sent a letter to DiGregorio advising her that it was reviewing her claim to determine her continued eligibility for LTD benefits under the "any occupation" provision. AR, at 329. While the parties dispute whether Pacific Mutual ever made a final determination as to such eligibility,[2] it is undisputed that DiGregorio continued

[2]DiGregorio states that "[i]t is undisputed that Plaintiff was found Totally Disabled under the terms and conditions of the LTD Plan during the application of the 'any occupation' portion of the definition of Total Disability, as she was paid benefits under the LTD Plan during the application of the period (from August 4, 1997, through April 16, 2001)." Plaintiff's Statement of Facts ¶ 18. While Defendants do not dispute that DiGregorio received benefits after August 1, 1997, they argue that the disbursement of benefits beyond the two-year period does not imply that Pacific Mutual made any determination of DiGregorio's eligibility under the "any occupation" provision. Defendants' Opposition to Plaintiff's Statement of Facts, at 2-3. To support their position, defendants note that while the June 2, 1997 letter stated that Pacific Mutual would "notify [DiGregorio] in writing when a decision of [her] continued eligibility has been rendered," there is no evidence in the record that Pacific Mutual

to receive benefits for a period well beyond August 1, 1997, which under the terms of the Plan fell under the "any occupation" provision. At points throughout both the "own occupation" and the "any occupation" periods during which DiGregorio received LTD benefits, Pacific Mutual requested various updated proofs regarding DiGregorio's disability, which DiGregorio apparently provided.[3]

2. Administrative Services Agreement Between PricewaterhouseCoopers and Hartford

The Plan defines the "Plan Administrator" as the "Sponsor," which the Plan separately identifies as Coopers. AR, at 21. In defining "Plan Administrator," however, the Plan further states that "[t]he PLAN ADMINISTRATOR may engage other firms or individuals to perform services for the PLAN." Id. As noted above, when DiGregorio submitted her original claim for LTD benefits in July of 1995, Pacific Mutual handled claims for LTD

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sent DiGregorio any such written notice. Id. As noted below, however, notes in Hartford's internal file on DiGregorio made soon after Hartford succeeded Pacific Mutual as the claims administrator the Plan indicate that Hartford initially determined that DiGregorio was disabled for any occupation. AR, 253. Moreover, the notes, which state that DiGregorio "remains db for any occ," imply that Pacific Mutual had considered DiGregorio to be disabled under the "any occupation" provisions of the Plan. Id. (emphasis added).

[3]The administrative record contains numerous requests by Pacific Mutual to DiGregorio for various materials. While many of the requests by Pacific Mutual were "2nd Requests" and "Final Requests," which indicated that DiGregorio's LTD benefits could be discontinued for failure to provide the requested documentation, it is undisputed that DiGregorio's continuously received benefits throughout the period that Pacific Mutual handled her claim.

benefits under the Plan. Plaintiff's Statement of Facts ¶ 11; Defendants' Statement of Facts ¶ 6.

On July 1, 1999, PricewaterhouseCoopers retained Hartford to administer claims under the Plan. AR, at 1. Under the "Long Term Disability Benefit Administration Agreement," made by the two companies, Hartford agreed to the following duties:

> We agree to evaluate and process all claims presented by or on behalf of Eligible Employees for payment of benefits according to the terms of the Plan as interpreted by [Hartford]. . . . We do not insure The Plan. We will not pay any benefits which are not, in our judgement, payable under The Plan.

Id. at 3.

3. Hartford's Discontinuance of DiGregorio's LTD Benefits

On August 5, 1999, Susan Peterson, a claims examiner for Hartford wrote the following in Hartford's internal file on DiGregorio:

> S: Per clmt hands are of no use to her now, fingers are numb, she drops things. She was scheduled for surgery, however, cancelled at last minute by workers' comp, she has anxiety and depression over this. She is in the process of settling her work comp claim.
> O: Dx Bilateral CTS, with RSD. Positive flexion test, there are no motor or sensory abnormalities. Surgical decompression has been recommended. Restrictions/Limitations. Perm restrictions on lifting, carrying, of 5 - 10 lbs. SS awarded, claim approved beyond test change.
> A: Based on medical in file clmt remains db for any occ. . . .
> P: Request Auth so that we may obtain Dr. Walsh's current records to determine if surgery has been performed and if any improvement noted.

AR, at 253.

In a letter to DiGregorio also dated August 5, 1999,

Peterson requested that DiGregorio sign and return an "Authorization to Obtain and Release Information." Id. at 76. Hartford subsequently requested information concerning adjustments to the amount of DiGregorio's LTD benefits,[4] and it also obtained further documentation from DiGregorio's physician, Dr. Walsh. Id. at 254-55.

On October 15, 1999, Peterson wrote in DiGregorio's file:

> Rec'd Dr. Walsh's office records for 2/5/99, 6/7/99 & 7/27/99.
>
> O: Recurrent carpal tunnel syndrome, s/p surgical decompression and she has had no change. Surgery has been recommended.
> 1. Clmt remains db until she has add'l surgery.
> P: Request updated medical in 3 months to determine if clmt has had add'l surgery and condition has improved.

Id. at 255.

On February 4, 2000, Matt Stelmachuck, another Hartford claims examiner, requested that DiGregorio have the physician who was currently treating her complete an "Attending Physician's Statement" to verify her continued disability. Id. at 92. On February 23, 2000, Stelmachuck made the following notes in DiGregorio's file:

> Rec'd and reviewed APS. Per AP, last appt. on 2/10/00. AP notes clmt's condition remains unchanged and clmt will be having surgery. Accordingly, since clmt's condition remains unchanged, and AP notes clmt will

[4]Hartford requested information from the Social Security Administration concerning DiGregorio's social security benefits and records from the Commonwealth of Massachusetts reflecting a lump sum workers' compensation award she received. AR, at 77, 83. Under the Plan, DiGregorio's LTD benefits were reduced by such payments. Id. at 88, 99.

have upcoming surgery, clmt remains TD for any occ.

Id. at 255.

On November 28, 2000, Hartford received a written narrative report by Dr. Douglas Howard, an orthopedic surgeon who examined DiGregorio on April 11, 2000. In the report, Dr. Howard wrote the following:

> Examination: She is complaining of pain and numbness involving the entire hand involving not only the index and thumb areas but also the little finger, which is conplaced not consistent with carpal tunnel syndrome of it's own nature. She is also describing electrical shocking type of pain into the hands that is intermittent from time to time.
>
> Impression: At this time she has reached maximum medical improvement for non-operative treatment and if she is truly approved for surgical intervention, she needs to have a full evaluation and surgery carried out. Otherwise she has reached end result with a permanent 5% loss of function in each hand.
>
> Recommendation: At this time I do not find her totally disabled but only partially disabled. She should have no repetitive activities or repetitive use of the hands, but this would allow any type of sedentary occupation that was non-repetitive. With her request for evaluation of a hand surgeon, I think it is entirely appropriate and I have suggested several to her today. She is to contact them and once arrangements are made for evaluation, I would be happy to forward medical records to them. At this time, I consider her discharged from care from this facility and further follow-up is not anticipated.

Id. at 215.

As a result of Dr. Howard's recommendations, James Powell, a third claims examiner for Hartford, wrote in DiGregorio's claim file on November 28, 2000 that

> [a]s claimant has been detemined [sic] only partially db at this time, TD any occ. is not supported. However, if claimant is to have surgery, need to

> determine if this will or has happened at this would impact her resulting functionality of her hands. The above exam was no 4-11-00. Need to f/up on status of CTR if performed.
>
> P: Contact claimant to determine if surgery has been performed and who surgeon and new AP are.

Id. at 259.

In a separate entry on November 28, 2000, Powell noted that he spoke with DiGregorio and she indicated that she was scheduled to have an electromyogram ("EMG") with her new physician, Dr. Jesse Jupiter, in December. Id. at 259. Powell further wrote:

> [DiGregorio] also said report just recv'd by Dr. Howard is not relevant because he only saw him once and it was for 5 minutes.
>
> A: Despite claimant's prohibition of Dr. Howard's comments, claimant does not appear TD at this time. However, if she is udnergoing [sic] EMG's and has expressed interest in rtw., feel that determination should be postponed until after report from Dr. Jupiter.

Id. In entries on February 5, 2001, Powell wrote that he spoke again with DiGregorio and that she indicated that she still had carpal tunnel syndrome, that it was disabling, and that she would have Dr. Jupiter submit verifying her condition. Id.

On March 16, 2001 Powell noted in DiGregorio's file that DiGregorio had not yet produced records from Dr. Jupiter and that Dr. Jupiter's address was not available. Id. at 259. He stated that because of the April 4, 2000 report[5] in which Dr. Howard did

[5]Powell refers to the "last review by Dr. Walsh on 4-00" but this seems to be a clerical error given the uncontradicted evidence of record that the April 4 exam was conducted by Dr. Howard. AR, at 259.

not find her to be totally disabled as to any occupation, he recommended denying the claim and referred the claim for further review. Id.

Also on March 16, 2001, Karen Swanson, yet another claims examiner for Hartford, wrote in the file:

> ee was released in 4/2000 with restrictions--we have rec'd no other med'l to support ee remains td from any and all occ. suggest claim be referred to rehab to see if jobs can be identified with r/l and her wage.

Id. at 260.

On March 20, 2001, Powell sent a letter to DiGregorio requesting, among other things, that she have her physician complete an Attending Physician Statement. Id. at 106. The same day, he filled out an "Test Change/Employability Analysis Referral Form," on which he stated that "claimant was a secretary. no work hx. Or education info. on file." Id. at 251. Referring to Dr. Howard's April 4 report, he indicated that DiGregorio did not have any limitations on standing, walking, sitting, driving, climbing, or kneeling but that her "Keyboard us/Repetitive hand motion" was "Very limited per AP." Id. at 252. In the margin of the form, Powell wrote: "capable of sed work no repetitive activity or repetitive use of hands." Id.

On March 22, 2001, Diane Polman, a rehabilitation clinical case manager for Hartford, used a computerized job matching system[6] to identify four occupations for which DiGregorio

[6]Polman used OASYS (Occupational Access System), which cross references an individual's qualification provide with occupations classified by the United States Department of Labor's 1991

possessed "direct transferable skills." Id. at 229, 260. These four occupations were: customer-complaint clerk, insurance clerk, information clerk and counter clerk. Id. at 229. In her report, Polman indicated that the results of the search found the four occupations to be at the "Good" level[7] and that all required occasional reaching, handling and fingering. Id. Additionally, the occupational descriptions for the four jobs variously required tasks involving writing, typing, and using a computer. Id. at 231-42. Upon reviewing the results of Polman's analysis, Powell recommended that DiGregorio's claim be denied because she did not meet the definition totally disabled as to any occupation, and Swanson agreed. Id. at 260.

On April 18, 2001, Powell sent a letter to DiGregorio informing her that Hartford had terminated her claim for LTD benefits:

> We have completed our review of your claim for benefits and have determined that the evidence submitted in support of your claim does not establish that you meet the Plan definition of Total Disability on or after April 16, 2001. Accordingly, LTD benefits are not payable under the Policy.

Id. at 107. The letter stated that the decision to deny benefits was based on the Plan language and "all documents contained in your claim file, viewed as a whole," including Dr. Howard's April

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Dictionary of Occupational Titles. AR, at 229.

[7]A "Good" match was the second best below "Closest" and above "Fair" and "Potential." AR, at 231. A "Good" match represented "Good to Moderate" transferability and required some training "in tools and/or materials." Id. The analysis produced no other matches in the other three categories. Id.

4, 2000 report, Polman's employability analysis, and telephone conversations with DiGregorio on November 28, 2000 and February 5, 2001. Id. at 108. In this regard, the letter noted that Dr. Howard's report concluded that DiGregorio was only partially disabled and could work in a sedentary position that did not require repetitive use of the hands, and it indicated that Hartford had identified four positions that were sedentary and did not require repetitive use of the hands. Id. The letter further stated that while DiGregorio had indicated in the telephone conversations that she would submit medical records from Dr. Jupiter, she had failed to do so to verify her continued disability. Id.

The letter stated that if DiGregorio had any additional information not previously submitted that she believed would assist Hartford in evaluating her claim, she could submit it for consideration within sixty days and Hartford would "review any additional information [she] submit[ed], along with the previously submitted information and notify [her] of the results of [its] review." Id. at 109. The letter also informed DiGregorio of her right under ERISA to appeal Hartford's decision in writing within sixty days of the date of the letter. Id.

4. DiGregorio's Appeal to Hartford

On April 23, 2001, DiGregorio spoke with Powell on the phone and told him that she was scheduled to have a medical appointment on May 31, 2001 and that she would forward to him medical information following that appointment. AR, at 261. On April

25, 2001, DiGregorio again spoke with Powell and requested that her benefits be reinstated. Id. Powell told her that he could not do so until he received updated medical records verifying her continued disability. Id. He further told her that she could send her records from Dr. Jupiter and that Hartford would contact Dr. Jupiter with questions or make a decision on the basis of the records alone. Id. Powell also advised DiGregorio to submit a letter of appeal. Id. On September 5, 2001, DiGregorio called Powell and informed him that she was having Dr. Jupiter submit further information.[8] Id.

In a letter dated September 25, 2001 to Powell, Stephen Raymond, counsel for DiGregorio, stated that to evaluate DiGregorio's claim he would need "all documents upon which [Hartford] ha[s] relied on in making [its] unfavorable determination" and thus requested that Hartford provide DiGregorio's "entire claim file." Id. at 112 (emphasis in original). Raymond additionally requested a copy of the summary plan description of the Plan and a number of other types of documentation indirectly related to DiGregorio's claim.[9] He

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[8]During the conversation, Powell also informed DiGregorio that she might not be able to appeal the denial decision because the sixty day appeal period had lapsed. Id. Hartford nevertheless considered DiGregorio's appeal and did not make further issue of her failure to indicate in writing her intent to appeal. In any event, Hartford does not raise the issue here.

[9]In the letter, Raymond requested documentation pertaining to any individuals' interpretations of DiGregorio's medical records, documents pertaining to DiGregorio's work background, training, or transferable skills, and any surveillance reports or videotapes. AR, at 112. The letter further stated:

further indicated that DiGregorio would be submitting any medical documentation necessary for the reinstatement of her claim. Id.

On September 25, 2001, Powell responded to Raymond's letter. Id. at 119. Powell stated that Raymond had asked for a copy of the Plan and "copies of the pertinent documents involved in making our determination to deny Ms. DiGregorio's claim for LTD benefits." Id. Powell stated that copies of the requested documents were enclosed, and he attached a copy of the Plan, Polman's employability analysis, and Dr. Howard's April 11, 2000 evaluation. Id. at 119-64.

On October 1, 2001, Raymond again wrote Powell, acknowledging receipt of Powell's letter and requesting again that DiGregorio's entire claim file be forwarded to him. Id. at 165.[10] Powell responded on October 8, 2001 in a letter stating

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> I am sure that you are aware that ERISA and its regulations mandate the claims procedure to be followed in this case. Specifically, 29 C.F.R. § 2560.503-1(g) requires a procedure by which the participant, or her duly authorized representative, may review pertinent documents. Any reports or other documents relating to or connected with a review of Ms. Digregorio's medical records by a member of your medical department, or outside consultant would be considered "pertinent documents." Accordingly, these documents, to the extent any exist, must be produced.

Id.

[10]The letter stated that the entire file included: all correspondence; internal notions; referrals to outside or inside vocational or medical sources; consultative vocational or medical reports; surveillance reports/videotapes/photographs; all medical documentation compiled to date; correspondence with any other insurance carrier; all claim documents, including the initial application documents; and all documents pertaining to the duties of Ms. DiGregorio's past occupation(s), her background, her training, her

that Hartford could not release any documents contained in DiGregorio's claim file not pertinent to the denial of her claim and that the documents already forwarded "are those used in making our determination." Id. at 170. Thus, Powell stated that Hartford was unable to honor the request for DiGregorio's entire claim file. Id.

On October 25, 2001, again requested DiGregorio's entire claim file:

> As it is our position that you must have, and indeed should have, considered Ms. DiGregorio's entire claim file in making a decision to terminate benefits on this claim, we again reiterate our request for a copy of the entire file. We believe Ms. DiGregorio is deprived a full and fair review of her claim absent the provision of these materials.

Id. at 172. By letter dated October 30, 2001, Powell responded:

> While Ms. DiGregorio's entire claim file has certainly been reviewed, the documents that pertain to the denial of her claim are, as you referenced, the Employability Analysis Report of 03/22/01 and the 04/11/01 evaluation by Dr. Douglas Howard. The most recent medical documentation we have on file indicates that Ms. DiGregorio is not Totally Disabled from any occupation, and, therefore, that is information used in making our determination to deny benefits.

Id. at 174.

On November 8, 2001, Raymond sent to Powell a letter documenting substantive reasons why DiGregorio's claim for LTD benefits should be upheld. Id. at 177. After recounting the history of DiGregorio's claim and her receipt of benefits up

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> occupational experience, and, documents relative to any transferrable skills.

AR, at 165. The letter also requested a copy of the insurance policy or certificate of coverage pertaining to the claim. Id.

until April 2001, Raymond stated that "[t]he question is, what changed in April of 2001, which led The Hartford to the conclusion that Ms. DiGregorio is no longer totally disabled under the terms of the Plan?". Id. at 179. He stated that reliance on Dr. Howard's April 11, 2000 assessment was unwarranted:

> She met with Dr. Howard only on the one occasion, on April 11, 2000, as he was standing in for Dr. Walsh, who had just left the practice. The "examination" consisted only of an 8-minute interview, wherein Dr. Howard did no ROM or strength testing, but merely had Ms. DiGregorio hold her hands out, palms-down, and subsequently turn them, palms-up. The written report, including the impression, is therefore based only upon this limited "examination," and Dr. Howard had only a limited understanding of Ms. DiGregorio's complicated history and continuing symptoms. What is made clear by the narrative, however, is that Dr. Howard did not have current EMG results to examine (the last testing having been done in 1997) and that Ms. DiGregorio had been considering further surgical intervention (which had been approved in connection with her on-going workers' compensation case). Dr. Howard notes that, if so, she "needs to have a full evaluation and surgery carried out." The evaluation was concluded with a referral to a hand surgeon for further evaluation.

Id. at 180.

In support of DiGregorio's claim that she was totally disabled as to any occupation, despite Dr. Howard's assessment, Raymond enclosed four items with his letter, which he claimed justified reversal of Hartford's decision to deny DiGregorio's claim: (1) an "EMG Laboratory report" from Massachusetts General Hospital from a test on November 29, 2000, (2) a February 6, 2001 letter from Dr. Jupiter, (3) a July 31, 2001 treatment note by Dr. Jupiter, and (4) a narrative letter from Dr. Jupiter dated October 12, 2001. Id. at 177-78.

In the EMG lab report, Dr. Katherine Wang wrote the following impression:

> Nerve conduction studies were remarkable for prolonged right median sensory and motor distal latancies:
>
> Needle EMG did not reveal any denervation in bilateral abductor pollicis brevis muscles.
>
> There is neurophysiologic evidence of chronic moderate median nerve dysfunction at the wrist on the right hand, which could be due to the old median nerve dysfunction. The prolonged left median F-response is of unclear clinical significance, which may be related to the previously known median nerve dysfunction.

Id. at 189.

In his February 6, 2001 letter, Dr. Jupiter stated that the EMG "shows substantial and serious compression of the median nerves in the carpal tunnel." Id. at 192. He further wrote:

> It would appear that the nerve is still bruised and you may require additional surgery. I believe that the problem can affect your ability to function and that you have at least for the present an ongoing disability as a result of this.

Id.

Dr. Jupiter's July 31, 2001 treatment note stated the following:

> The patient continues to have ongoing problems. She had an EMG and nerve conduction study which afforded a compressive neuropathy in the median nerve. This interferes with her ability to function. She remains disabled because of this and will do so on a continuous basis unless intervention proves successful. I would ask her to consider intervention at this point. Her prognosis is guarded.

Id. at 193.

Finally, Dr. Jupiter's October 12, 2001 letter, addressed to Raymond states the following:

> I have been treating Ms. DiGregorio since the 25th of May in the year 2000. She continues to have ongoing problems with median nerve compression in her hands. An EMG and nerve conduction study confirms that she still has dysfunction of her nerve. On the basis of this and her symptoms she continues to be disabled in her secretarial line of work and feels that she is unable to perform bimanual tasks in any form of work.

Id. at 194.

On November 14, 2001, Powell wrote in DiGregorio's file that "[t]he medical supplied does support ongoing TD own occ., but not any occ." Id. at 263. He further wrote that Dr. Jupiter

> states clearly in his final letter that he believes she cannot perform her own occ., but that EE does not feel she is capable of any bimanual tasks. This is not objective medical documentation to support an inability to perform any occ. Additionally, the occs. identified require very little repetitive use of the hands.

Id. Powell concluded that DiGregorio's claim was not supported, but he suggested that the claim be reviewed by Hartford's Medical Advisory Group.[11] Id.

The claim was subsequently referred to Jody Wilkins, a nurse employed by Hartford. Id. at 205. After recounting the background to DiGregorio's claim, Wilkins wrote the following in DiGregorio's file:

> The previous EMG/NCS findings noted only mild median nerve entrapment & the EMG/NCS performed on 11/29/00 is difficult to read as both the motor & sensory latencies appear to show only mild median nerve dysfunction, yet the interpreter concluded differently. Also, 2 physicians have noted that EE's sx are not classical for CTS. Dr. Howard's R/Ls from 4/11/00 appear to be appropriate given EE's hx of B CTRs & her ongoing sx & therefore the EA findings would be accurate. Will

[11]In the file, Powell recommended that the file be referred to "MCCM," which apparently refers to the Medical Advisory Group.

> attempt to s/w Dr Jupitor clarifying whether there have been any clinical findings consistent w/CTS, why mild median nerve dysfunction would limit EE from any occ, & to discuss EE's hx of multiple insurance claims.

Id. at 264-65.

On December 4, 2001, Wilkins faxed to Dr. Jupiter a one-page letter, which stated in part: "Based on restrictions given by Dr. Howard on 4/11/00, it was determined that she was capable of other occupations & benefits were denied. To better understand her condition, we need clarification on the following issues." Id. at 220. The letter contained six questions to which Dr. Jupiter responded on December 5, 2001. Id.

In the first question, Wilkins stated that both an independent medical examiner, in 1997, and Dr. Howard, in 2000, indicated that DiGregorio's symptoms were not consistent with carpal tunnel syndrome, and she asked what "objective clinical (not including diagnostic tests) findings" led Dr. Jupiter to believe that DiGregorio had carpal tunnel syndrome. Id. In response, Dr. Jupiter indicated that he had relied on "clinical history & exam" and the EMG of November 29, 2000. Id.

In the second question, Wilkins asked whether the November 29, 2000 EMG, which showed chronic & moderate median nerve dysfunction, had been reviewed against a 1997 EMG, which showed mild dysfunction. Id. Dr. Jupiter suggested that she contact the neurologist who performed and interpreted the exam. Id.

In the third question, Wilkins asked whether Dr. Jupiter knew if DiGregorio had worked since February of 1995, and he stated he did not know. Id.

In the fourth question, Wilkins asked why, if surgery was needed, DiGregorio did not pursue it, especially given that Dr. Walsh had been seeking approval for it since 1998. Id. Dr. Jupiter wrote: "ask patient--perhaps she sought expertise here at MGH." Id.

In the fifth question, Wilkins asked: "Do you agree with the following restrictions given by Dr. Howard: No repetitive activities or repetitive use of hands? Please explain why or why not and give your suggested work restrictions." Id. In response, Dr. Jupiter wrote "yes." Id.

Finally, in response to a question asking whether he was involved with any previous insurance claims by DiGregorio, Dr. Jupiter stated that he was not. Id. After receiving Dr. Jupiter's responses, Wilkins wrote in DiGregorio's file: "Dr. Jupiter is agreeing w/ Dr Howard's R/Ls from 4/00 for which the previous EA turned up positions, therefore, it appears that TD any occ is not supported." Id. at 265.

By letter dated December 12, 2001, Powell wrote to Raymond informing him that Hartford had completed its review of the additional information supplied by DiGregorio and had determined that because her condition did not meet the Plan definition of totally disabled after April 16, 2001, it would uphold its determination to deny her claim of LTD benefits. Id. at 202. The letter stated that it appeared that DiGregorio had only been treated three times between January 1, 2000 and July 31, 2001, which indicated that she was not under the "regular care" of a

physician as required by the Plan. Id. The letter further stated that "there is no medical documentation to support [DiGregorio's] inability to perform an occupation that does not require repetitive hand motion." Id. at 203. It noted that Dr. Jupiter's October 12, 2001 letter stated only that DiGregorio was disabled from her own occupation and that DiGregorio felt that she was unable to perform bimanual tasks of any kind. Id. It also cited Dr. Jupiter's response to Wilkins's letter which indicated that he agreed with the restrictions suggested by Dr. Howard. Id. Noting again that Hartford had identified four jobs that DiGregorio perform given those restrictions, the letter stated that Hartford had concluded that DiGregorio was not totally disabled as to any occupation. Id.

DiGregorio brought this action on June 23, 2003 seeking declaratory relief under 29 U.S.C. § 1132(a)(1)(B) ("§ 1132(a)(1)(B)"), the civil enforcement provision of ERISA which allows suits by plan participants to recover benefits.[12] She contends that Hartford erred in its determination that she was not disabled under the Plan, and she seeks the reinstatement of her LTD benefits both prospectively and retroactively back to

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[12]Section 1132(a)(1)(B) provides:

> A civil action may be brought--
> (1) by a participant or beneficiary-
> . . .
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

April 16, 2001, the date Hartford discontinued the benefits. She additionally argues that by refusing to provide her entire claim file, Hartford denied her the right to a full and fair review provided by § 503(2) of ERISA.

II. DISCUSSION

A. Standard of Review

1. Grant of Discretionary Authority

Under the Supreme Court's decision in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), a denial of benefits challenged under § 1132(a)(1)(B) "is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Id. at 115. The First Circuit has "steadfastly applied Firestone to mandate de novo review of benefits determinations unless 'a benefits plan . . . clearly grant[s] discretionary authority to the administrator.'" Terry v. Bayer Corp., 145 F.3d 28, 37 (1st Cir. 1998) (quoting Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 583 (1st Cir. 1993)); see Allen v. Adage, Inc., 967 F.2d 695, 698 (1st Cir. 1992) (de novo review appropriate where "nothing in the Plan indicates that another approach is to be used"); Bellino v. Schlumberger Technologies, Inc., 944 F.2d 26, 29 (1st Cir. 1991) (de novo review appropriate where defendant "points to no language in the Plan giving it the 'discretionary authority' required"). Where a plan grants such discretion, a court evaluating the § 1132(a)(1)(B) claim applies a deferential

arbitrary and capricious standard of judicial review to the administrator's determination. Terry, 145 F.3d at 37.

Defendants point to the following language in the Plan as a grant of discretionary authority sufficient to warrant the deferential standard of review:

> Upon receipt of due proof that, as a result of pregnancy, accidental bodily injury, or sickness, an employee sustained a TOTAL DISABILITY which began while his coverage for this benefit was in force and was continuous for at least the Elimination Period specified in the Schedule of Benefits, the SPONSOR will pay an income benefits as described below, subject to the following provisions and the other provisions of the PLAN.

AR, at 28. Additionally, defendants contend that language in the 1992 "Summary Plan Description" ("1992 SPD") for the Plan is further evidence of a discretionary grant of authority to the administrator of the Plan:

> To receive LTD benefits you must file a claim form with Pacific Mutual and provide such additional medical and other evidence of your disability as Pacific Mutual may reasonably require.
>
> To continue to qualify for disability benefits, you must continue to be under the care of a legally qualified physician unless the disability has been declared permanent by Pacific Mutual.
>
> . . .
>
> From time to time, you will be required to provide proof of continuing disability. The insurance company reserves the right to visit you to confirm your disability and/or to have you examined by a physician of their choice.

Id. at 63.

a. Relevance of Summary Plan Description -- As an initial

matter, the parties dispute the applicability of the 1992 SPD. DiGregorio contends that the language in the 1992 SPD is not here relevant because it specifically refers to Pacific Mutual, not to Hartford.[13] In response, Hartford argues that while the 1992 SPD specifically names Pacific Mutual, it applies more generally to the claims administrator of the Plan, a position which Pacific Mutual held at the time the 1992 SPD was written but to which Hartford later succeeded. On this point, I agree with Hartford.

Under ERISA, a plan administrator is required to distribute to participants a summary plan description, which provides a accessible, plain-language description of a beneficiary plan.[14] To this end, the summary plan description must be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a). Because Coopers hired several different companies to

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[13]The First Circuit has not directly decided what documents, if any, other than a benefit plan itself should be considered in determining whether a plan grant sufficient discretionary authority to warrant a deferential standard of review under Firestone, but several courts have considered language in a plan's summary plan description relevant to the determination. See Sidou v. Unumprovident Corp., 245 F. Supp. 2d 207, 218 (D. Me. 2003); Wade v. Life Ins. Co. of N. Am., 271 F. Supp. 2d 307, 319 (D. Me. 2003). In any event, while DiGregorio contends that the 1992 SPD is inapplicable here, she does not dispute the more general point that a summary plan description can be considered in determining whether there was a sufficient grant of discretionary authority.

[14]The plan administrator is required to furnish a summary plan description within 90 days of when one becomes a participant or beneficiary. 29 U.S.C. §§ 1024(b)(1)(A)-(B).

handle different types of claims under the Plan,[15] it makes sense that the 1992 SPD specifically named Pacific Mutual, rather than referring generically to the claims administrator for LTD benefits, to make it clear to participants which company would administer their LTD benefits.

Perhaps more importantly, because § 1024(b) requires that a summary plan description accompany the Plan and because DiGregorio nowhere suggests that a summary plan description other than the 1992 SPD was applicable at any point during the time period at issue in this case,[16] either the 1992 SPD applied to Hartford or there was no applicable summary plan description in violation of § 1024(b). There is, however, no support for the latter. There is no evidence, nor does DiGregorio even suggest, that the Plan, or the description of the Plan as set forth in the 1992 SPD, changed in any way when Hartford took over Pacific Mutual's claim administration duties. The fact that the 1992 SPD mentions Pacific Mutual by name rather than role is thus not enough to make it void once Hartford succeed Pacific Mutual as claims administrator. The 1992 SPD nowhere indicates that its

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[15]Coopers initially contracted Pacific Mutual to handle life and disability insurance claims and American International Life Assurance Company of New York to handle welfare accident insurance claims. AR, at 71.

[16]Section 1024(b) requires that a plan administrator provide an updated summary plan description five years after the plan becomes subject to ERISA if there are any amendments to the plan. 29 U.S.C. § 1024(b)(1). DiGregorio does not suggests that amendments to the 1992 SPD were or should have been made or that defendants otherwise failed to comply with the requirements of § 1024.

descriptions of the Plan are in any way particularly tied to Pacific Mutual; its references to the Pacific Mutual are as the claims administrator and Pacific Mutual's described role is, on its face, entirely transferable. I thus conclude that the 1992 SPD applies to Hartford.

That having been said, the conclusion that the 1992 SPD applies to Hartford makes little difference in the end because neither the language in the 1992 SPD or the language in the Plan constitutes a grant of discretionary authority that warrants a deferential standard of review in this case.

b. The Question of Discretion -- Defendants contend that a deferential standard of review is warranted because the Plan and SPD grant Hartford the discretion to (1) determine whether a claimant has provided "due proof" of a total disability, (2) request additional evidence of a claimant's disability as Hartford "may reasonably require," (3) require a claimant to treat regularly with a physician unless it declares a disability to be permanent, and (4) require a claimant to undergo physical examination to confirm a disability. Defendants' Memorandum in Support of Summary Judgment, at 5-6. I conclude that this is insufficient to warrant a deferential standard under Firestone.

To begin, the Plan's requirement that a claimant provide "due proof" of a disability does not constitute a grant of discretionary authority. In Brigham v. Sun Life of Canada, 317 F.3d 72 (1st Cir. 2003), the First Circuit examined a benefit plan which stated that the insurer "may require proof in

connection with the terms or benefits of [the] Policy," id. at 81, and further stated: "If proof is required, we must be provided with such evidence satisfactory to us as we may reasonably require under the circumstances." Id. (emphasis in original). The Brigham court seized on the latter sentence and ultimately agreed with other circuits which have held that the "satisfactory to us" language imparted sufficient discretionary authority to warrant deferential review under Firestone. Id. Though it did not explicitly so hold, the Brigham court implied that policy language merely requiring "satisfactory proof" was insufficient to trigger deferential review, noting that a number of circuits have distinguished "satisfactory to us" language from "policies that simply require 'satisfactory proof' of disability, without specifying who must be satisfied" and that only the Sixth Circuit had held the latter language to be a sufficient grant of discretionary authority. Id. Indeed, the court indicated that even the "satisfactory to us" language might not be sufficient, but it ultimately decided to follow the other circuits' lead to conclude that it was. Id. at 82. Thus, Brigham strongly suggests that language requiring "satisfactory proof" is not sufficient to warrant deferential review, and consequently, I find that the Plan's requirement that a claimant provide "due proof," which is not in any significant way different from "satisfactory proof," does not negate the presumption of de novo review. See Perez-Rivera v. Cornell Univ., 297 F. Supp. 2d 412, 414-15 (D.P.R. 2003).

Similarly, I find that the language in the 1992 SPD allowing the administrator to request additional evidence of a claimant disability, require a claimant to treat regularly with a physician unless it declares a disability to be permanent, and require a claimant to undergo physical examination to confirm a disability does not confer on the administrator any substantial discretionary authority for purposes of determining the proper standard of review. See Grady v. Paul Revere Life Ins. Co., 10 F. Supp. 2d 100, 110 (D.R.I. 1998) (no discretionary authority where policy required claimants "to submit proof of claim, proof of loss, and written proof of entitlement, as well as provisions providing defendant with the right to request additional information and to order an independent medical examination"); Hersee v. First Allmerica Financial Life Ins. Co., No. 99-10224, 2002 WL 745805 at *3 (D. Mass. 2002) (unpublished disposition) (no discretionary authority where policy required timely proof of continued disability, proof of regular attendance of a physician, and medical exam as the insurer reasonably required). But see Gerhold v. Avondale Indus., Inc., No. 02-3386, 2004 WL 602778 at *3-4 (E.D. La. 2004) (unpublished disposition) (deferential standard warranted where policy required written proof of loss and allowed administrator to order physical examination whenever reasonably necessary).

In Grady, the court stated that the provisions at issue in that case

> are flatly insufficient under Firestone and First Circuit precedents. They are simply garden-variety

> contract terms specifying the procedure by which claims are to be processed, and by which the Policy is to be administered. It would require a logical leap of Olympic proportions to find that these provisions give defendant the last word in interpreting the contract, or in determining eligibility for benefits. While a benefit plan undoubtedly may do so, the Policy undoubtedly did not.

10 F. Supp. 2d at 110 (citations omitted). I conclude likewise with regard to the provisions in the 1992 SPD.[17]

The fact that the 1992 SPD grants Hartford the authority to request additional evidence of a claimant's disability as it "may reasonably require," does not alter this conclusion. If anything, the "reasonably require" language seems to limit, rather than conferring discretion on, Hartford in requesting evidence from a claimant, see Helm v. Sun Life Assurance of Canada, Inc., 34 Fed. Appx. 328, 2002 WL 726487 at *2 (9th Cir. 2002) (unpublished disposition). In any event, I find that because the language relates to Hartford's authority to request information, as opposed to Hartford's evaluation of the information in determining eligibility for benefits, it does not speak to the question of discretionary authority for the purposes

[17]My opinion in Guarino v. Metropolitan Life Ins. Co., 915 F. Supp. 435 (D. Mass. 1995), does not suggest a different conclusion. While in determining in Guarino that a deferential standard of review was appropriate, I noted provisions similar to those in the 1992 SPD, the grant of discretionary authority was found primarily in policy language stating: "All proof of claim must be satisfactory to the Insurance Company." Id. at 444 (emphasis in original). As noted previously, under Brigham, this language alone is sufficient to trigger a deferential standard of review, and there is no comparable language in this case.

of determining standard of review.[18]

In sum, keeping in mind that "there are no 'magic words' determining the scope of judicial review of decisions to deny benefits," Brigham v. Sun Life of Canada, 317 F.3d 72, 81 (1st Cir. 2003) (quoting Herzberger v. Standard Ins. Co., 205 F.3d 327, 331 (7th Cir. 2000)), I conclude that a deferential arbitrary and capricious standard of review is unwarranted in this case. Under Firestone only a clear grant of substantial discretionary authority warrants a deferential standard of review, see Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 385-86 (2002) ("[The Firestone Court] held that a general or default rule of de novo review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion."), overruled in part on other grounds by Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003), and the provisions in the Plan and 1992 SPD identified by defendants do not provide such a grant.[19] Accordingly, I turn to application of the de

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[18]Indeed, in Brigham, the policy at issue stated that a claimant must provide "evidence satisfactory to us as we may reasonably require under the circumstances," 317 F.3d at 81 (emphasis omitted), and in assessing whether there was a grant of discretionary authority warranting deferential review, the court focused on the "satisfactory to us" language, ignoring altogether the "as we may reasonably require" language. Id.

[19]Because I conclude that de novo review is appropriate in this case, I need not address DiGregorio's claim that an arbitrary and capricious standard of review should include consideration of potential and actual conflicts of interest on the part of Hartford. Plaintiff's Motion for Judgment on the Administrative Record, at 5.

novo review standard.

2. Summary Judgment Protocol and ERISA De Novo Review

The parties initially framed the issues through cross-motions for summary judgment. Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). Thus, ordinarily, if the party seeking summary judgment can make a preliminary showing that no genuine issue of material fact exists, the nonmovant can resist summary judgment by pointing to specific facts demonstrating that there is, indeed, a trialworthy issue.[20] Calero-Cerezo v. United States Dept. of Justice, 355 F.3d 6, 19 (1st Cir. 2004).

ERISA cases such as this, however, present a somewhat special situation when put into a summary judgment posture. In general, there appears to be a presumption, if not a rule, in favor of deciding § 1132(a)(1)(B) cases solely on the basis of the administrative record, whether the standard of review is arbitrary and capricious or de novo. See Liston v. UNUM Corp.

[20]Cross-motions for summary judgment do not alter the basic summary judgment standard, but rather require courts to determine whether either of the parties deserves judgment as a matter of law on facts that are not disputed. See Adria Int'l Group, Inc. v. Ferre Dev., Inc., 241 F.3d 103 (1st Cir. 2001); Wightman v. Springfield Terminal Ry. Co., 100 F.3d 228, 230 (1st Cir. 1996). Thus, in deciding cross-motions for summary judgment, courts must consider each motion separately, drawing inferences against each movant in turn. Reich v. John Alden Life Ins. Co., 126 F.3d 1, 6 (1st Cir. 1997).

Officer Severance Plan, 330 F.3d 19, 23-24 (1st Cir. 2003) ("The ordinary rule is that review for arbitrariness is on the record made before the entity being reviewed. . . . Even where de novo review exists under ERISA, it is at least doubtful that courts should be in any hurry to consider evidence or claims not presented to the plan administrator."). In any event, in the present case, neither party seeks to introduce any evidence other than the administrative record upon which Hartford based its decision to deny DiGregorio's LTD benefits--indeed, DiGregorio styles her motion as a "Motion for Judgment on the Administrative Record."

Because the First Circuit has held that jury trials are not available for cases to be decided solely on the administrative record, see Recupero v. New Eng. Tel. & Tel. Co., 118 F.3d 820, 831 (1st Cir. 1997); Liston, 330 F.3d at 24 n.4, a § 1132(a)(1)(B) case that survives summary judgment may lead to a bench trial that is nothing more than a parallel to summary judgment practice: a re-presentation of the administrative record to the same judge. See Radford Trust v. First Unum Life Insurance Co. of Am., 321 F. Supp. 2d 226, 239 (D. Mass. 2004). Such wasted effort can be avoided in cases involving a deferential standard of review because the summary judgment standard in those cases is altered by the substantive law, see Liston, 330 F.3d at 24 (where review is under arbitrariness standard, "summary judgment is merely a mechanism for tendering the issue and no special inferences are to be drawn in favor of a

plaintiff resisting in summary judgment; on the contrary, the rationality standard tends to resolve doubts in favor of the administrator"), but in cases involving de novo review, the ordinary summary judgment standard is arguably applied. See Radford, 321 F. Supp. 2d at 239 (citing First Circuit cases indicating that summary judgment standard is appropriate).

During the motion hearings associated with the present cross-motions, upon inquiry by me whether this case might be resolved as a bench trial on a case stated by the administrative record, the parties agree to that procedure. Accordingly, I will treat the administrative record as though it had been developed on a bench trial and will make final findings of fact determinations as to the underlying merits of the case.

B. Proper Parties

Before turning to the merits, I pause to address Hartford's contention that it is not a proper party in this suit. Hartford claims that because it is merely a third party administrator for the Plan and does not pay any claims from its own funds, it is not liable under § 1132(a)(1)(B). I disagree.

Under § 502(d)(2) of ERISA,

> [a]ny money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

29 U.S.C. § 1132(d)(2). Some courts have held that under this provision a plan is the only proper defendant in a suit arising under § 1132(a)(1)(B). See Jass v. Prudential Health Care Plan,

Inc., 88 F.3d 1482, 1490 (7th Cir. 1996); Lee v. Burkhart, 991 F.2d 1004, 1009 (2d Cir. 1993); Gibson v. Prudential Ins. Co. of Am., 915 F.2d 414, 417 (9th Cir. 1990). Other courts, however, have held that a plan administrator may also be sued under § 1132(a)(1)(B). See Layes v. Mead Corp., 132 F.3d 1246, 1249 (8th Cir. 1998) (plan administrator, not employer, was proper party defendant); Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186, 187 (11th Cir. 1997) (per curiam) (employer was plan administrator and thus proper party defendant); see also Daniel v. Eaton Corp., 839 F.2d 263, 266 (6th Cir. 1988) ("Unless an employer is shown to control administration of a plan, it is not a proper party defendant in an action concerning benefits."), cert. denied, 488 U.S. 826 (1988); see generally Hall v. LHACO, Inc., 140 F.3d 1190, 1194-95 (8th Cir. 1998) (summarizing line of cases).

While the First Circuit has not addressed the issue head-on, it has indicated that it agrees with the line of cases that allow a plan administrator to be sued under § 1132(a)(1)(B). In Terry, the district court had granted summary judgment against the defendant employer, stating that the plan was the proper defendant in a § 1132(a)(1)(B) action, but the court declined to address issue because it agreed that summary judgment was appropriate as to the merits of the claim. 145 F.3d at 34 n.5. Nevertheless, in deciding whether a decision by an insurance company that serviced the plan was the appropriate decision to consider on review under § 1132(a)(1)(B), the court stated that

"[t]he proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan." 145 F.3d at 36 (quoting Garren, 114 F.3d at 187). Moreover, the First Circuit has decided a number of cases brought against only plan administrators, without any hint that such suits are improper. See, e.g., Larocca v. Borden, Inc., 276 F.3d 22 (1st Cir. 2002); Pari-Fasano v. ITT Hartford Life and Acc. Ins. Co., 230 F.3d 415 (1st Cir. 2000); see generally Cook v. Liberty Life Assurance Co. of Boston, No. 00-408, 2002 WL 482572 at *2 (D.N.H. 2002) (unpublished disposition) (citing additional cases). I therefore conclude that the plan administrator is a proper party defendant in a suit arising under § 1132(a)(1)(B).

The question, then, is whether Hartford is in fact the administrator of the Plan. As noted above, while the Plan defines the "Plan Administrator" as the "Sponsor," which it elsewhere identifies as Coopers, the Plan further states that "[t]he PLAN ADMINISTRATOR may engage other firms or individuals to perform services for the PLAN." In fact, Coopers did so, retaining first Pacific Mutual and later Hartford to handle claims under the Plan. Strictly speaking under the terms of the Plan, Coopers (and hence PricewaterhouseCoopers) remains the "Plan Administrator," even if it delegates the task of "performing services" to another party as it did with Hartford. But as the Terry court suggested, the focus is not on labels but rather on function and, specifically, what party "controls the

administration of the plan."[21] 145 F.3d. at 36.

Here, there is little question that Hartford controlled the administration of the Plan. Under the "Long Term Disability Benefit Administration Agreement" made by the two companies, Hartford agreed to the following duties:

> We agree to evaluate and process all claims presented by or on behalf of Eligible Employees for payment of benefits according to the terms of the Plan as interpreted by [Hartford]. . . . We do not insure The Plan. We will not pay any benefits which are not, in our judgement, payable under The Plan.

AR, at 3. Additionally, a section of the agreement entitled "Claim Fiduciary Provisions to the Long Term Disability Benefits Administration Agreement" provides:

> [Hartford] agree[s] to accept the following claim fiduciary responsibilities, pursuant to ERISA, in relation to the Plan:
>
> A. Interpret all relevant provisions of the Plan which relate to the amount of, or eligibility for, benefits under the Plan.
> B. Pay, deny or terminate claims first arising after the effective date of the Agreement, according to [Hartford's] interpretation of relevant provisions of the Plan.
> C. Handle appeals related to claims denials or terminations made by [Hartford].
> D. Manage, defend, and, in [Hartford's] sole discretion, settle all litigation contesting claim denials or terminations made by [Hartford]. [Hartford] will consult [PricewaterhouseCoopers] in connection with any such litigation.
>
> [PricewaterhouseCoopers] agree[s] that [Hartford] will have no fiduciary responsibilities in relation to [the] Plan to:
>
> A. Manage plan assets.

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[21]Defendants do not contest that the Plan is an appropriate party.

> B. Make plan design decisions.
>
> [PricewaterhouseCoopers] agree[s]:
>
> . . .
>
> B. To retain full responsibility, discretion, and authority to determine eligibility of [PricewaterhouseCoopers] employees for participation in the Plan.
>
> . . .
>
> E. To delegate to [Hartford] full responsibility, discretion, and authority to interpret all terms of the Plan necessary to fulfill [Hartford's] obligations under the Agreement.
>
> F. To delegate to [Hartford] full responsibility, discretion, and authority to make claims determinations, handle appeals and manage, defend, and settle all litigations involving [Hartford's] denial or termination of plan benefits.
>
> . . .
>
> H. To take no action overruling or contradicting a claim determination made by [Hartford].

Id. at 16.

Thus, under the agreement Hartford does more than "merely process claims." Terry, 145 F.3d at 36. Indeed, the only authority Coopers retained under the agreement was to determine the eligibility for participation in the Plan, as opposed to the eligibility for benefits, and to make decisions about the Plan assets and design. Hartford had the authority and discretion to manage all aspects of the claim administration, from interpretation of the Plan to the actual disbursement of benefits

and throughout the appeal of its determinations.[22] Coopers retained no authority to second-guess Hartford's decisions regarding particular claims.

This stands in stark contrast to the situation in Terry, where the court held that the decision to deny benefits by the insurance company was not the final decision to be reviewed under § 1132(a)(1)(B) because the plan administrator retained discretion to decide disputed claims and there was "nothing to suggest that [the insurance company] was doing anything other than applying the terms of the Plan as written to Terry's particular situation." Id.; see Garren, 114 F.3d at 187 (servicer of plan, which did not exercise any discretion, responsibility, or control over the administration of the plan, not proper party defendant). In fact, as the Terry court noted, the agreement between the insurance company and the employer in Terry required the former to adhere to the latter's

[22]This does not affect the earlier conclusion that de novo review is appropriate in this case. That the agreement between Coopers and Hartford grants Hartford substantial discretionary authority does not change the fact that the Plan itself does not grant to Coopers sufficient discretionary authority to warrant deferential review. Cf. Rodriquez-Abreu, 986 F.2d 580 (where plan grants discretionary authority, there is a subsequent question of whether such authority was delegated to the plan administrator); Mario v. P&C Food Mkts., Inc., 313 F.3d 758, 762 (2d Cir. 2002) (summary plan description reference service agreement which granted discretion to service provider). In other words, while the agreement appears to grant to Hartford all discretionary authority to administer claims that is contemplated by the Plan-- which for purposes of the present inquiry gives Hartford control of the administration of claims under the Plan-- the agreement cannot be said thereby to create more discretionary authority than is afforded by the Plan.

determinations.[23] The reverse is true here.

C. Merits

1. Totally Disabled as to "Any Occupation"

According to DiGregorio, the relevant question in this case is: what changed in her condition from the time when Hartford had determined that she was totally disabled with respect to "any occupation" to cause it to deny the LTD claim in April of 2000? Plaintiff's Memorandum in Support of Her Motion for Judgment on the Administrative Record, at 7. This is, of course, a rhetorical question; she contends that because nothing changed in her condition prior to April 2000, Hartford had no basis for terminating her LTD benefits.

As an preliminary matter, I note there is no evidence that Hartford ever made an explicit determination that DiGregorio was disabled under the "any occupation" provision of the Plan. For that matter, defendants dispute whether Pacific Mutual made such a determination, despite the fact that DiGregorio received benefits well into the "any occupation" period. Thus, DiGregorio's starting assumption that Hartford changed course by

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[23]The Terry court suggested that the fact that a third party servicer that merely processes claims is not a fiduciary might also factor into the equation. 145 F.3d at 35-36. It is not entirely clear why whether a party is a fiduciary under ERISA would be relevant to a case under § 1132(a)(1)(B), see Everhart v. Allmerica Fin. Life Ins. Co., 275 F.3d 751, 756 (9th Cir. 2001) (comparing suits under § 1132(a)(1)(B) with suits under § 1132(a)(3) for breach of fiduciary duty), cert. denied, 536 U.S. 958 (2002), but in any event, it is clear from the agreement between Coopers and Hartford that Hartford had sufficient responsibilities to qualify as a fiduciary as described in Terry. 145 F.3d at 35-36 (citing 29 C.F.R. § 2509.75-8, D-2 (1997)).

denying her claim appears misplaced.

In any event, even assuming that Hartford had initially, albeit implicitly, determined that DiGregorio was entitled to LTD benefits, it was certainly authorized under the Plan to reverse that decision. As noted above, the 1992 SPD provided that "[f]rom time to time, [a claimant] will be required to provide proof of continuing disability." AR, at 63. Thus, under the Plan, Hartford could deny LTD benefits if it determined that DiGregorio was no longer totally disabled as to any occupation. This is exactly what it did on the basis of Dr. Howard's April 2000 narrative report, and it was up to DiGregorio to prove affirmatively that she was, despite Dr. Howard's report, totally disabled as to any occupation.

In his report, Dr. Howard wrote the following:

> At this time I do not find her totally disabled but only partially disabled. She should have no repetitive activities or repetitive use of the hands, but this would allow any type of sedentary occupation that was non-repetitive.

Id. at 215. Thus, it was Dr. Howard's opinion, in no uncertain terms, that DiGregorio was not to be considered totally disabled as to any occupation.

DiGregorio contends that Dr. Howard's report was unreliable. She asserts that the visit lasted approximately eight minutes and that Dr. Howard did not perform any clinical testing. Moreover, she notes that Dr. Howard did not rely on any EMG testing. DiGregorio thus concludes that Dr. Howard's report should not be taken as conclusive evidence that she was not totally disabled as

to any occupation.[24]

DiGregorio's contentions, of course, go to the weight that attaches to Dr. Howard's report. But I find Dr. Howard's report persuasive that she was not totally disabled as to any occupation as of April 2000. The focus thus is less on the potential deficiencies in Dr. Howard's report than on what evidence DiGregorio has adduced to rebut the report and demonstrate that she was in fact totally disabled as to any occupation after April 2000.

The sum of evidence that DiGregorio offered to Hartford (and

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[24]DiGregorio suggests further that Hartford's determination that she was not totally disabled as to any occupation was incorrect because Hartford was unable to find any occupations that she could perform given her condition, even as described by Dr. Howard. She argues that because the four occupations identified by Polman required "occasional reaching, handling, and fingering" and also required various tasks like writing and typing, they did not meet Dr. Howard's recommended restrictions of no repetitive activities. I find the argument unpersuasive.

The fact that DiGregorio believes the tasks involved in the four occupations qualify as repetitive does not by itself make them so. Neither do I agree with DiGregorio's claim that Powell's internal note that the occupations "require very little repetitive use of her hands" acts as a determinative admission that the occupations that DiGregorio could not perform. In short, Polman identified the four occupations as meeting the restriction set by Dr. Howard, and DiGregorio has adduced no evidence, other than her conclusory assertions that they include repetitive tasks, that she could not perform those occupations. Moreover, her claims that Polman's analysis should have included additional restrictions--such as psychological symptoms and pain associated with her condition as well as diminished ability to climb, balance, stoop, kneel, crouch, crawl, or reach--is not supported anywhere in the record. Finally, I note that while the four positions Polman identified involve capacities similar to that of a secretary, they are only the nearer elements of a large universe of jobs DiGregorio could perform. No doubt other jobs might be less demanding or prestigious but it is DiGregorio's obligation to demonstrate she is unable to perform "any job" for which she is qualified, even if she is overqualified.

consequently here since she seeks judgment on the administrative record) to demonstrate her total disability beyond April 2000 consists of Dr. Jupiter's February 6, 2001 letter, his July 31, 2001 treatment notes, his October 12, 2001 narrative letter, and the November 29, 2000 EMG results. This collection of evidence, however, is insufficient to support DiGregorio's claim.

It is not disputed that the EMG testing indicated nerve damage to DiGregorio's right hand. Indeed, the analysis flatly states that the test provided "neurophysiologic evidence of chronic moderate median nerve dysfunction at the wrist on the right hand." Id. at 189. And to be sure, Dr. Jupiter's letters, as well as his treatment notes, indicated that, at least in Dr. Jupiter's opinion, DiGregorio had an ongoing disability.

The problem is that this evidence does not conflict with Dr. Howard's finding that DiGregorio was partially disabled. In other words, nowhere in the four items DiGregorio submitted to Hartford is there evidence of a total disability as to any occupation. The closest to such evidence is in the October 2001 letter, in which Dr. Jupiter stated: "On the basis of this and her symptoms she continues to be disabled in her secretarial line of work and feels that she is unable to perform bimanual tasks in any form of work." Id. at 194. Even assuming an inability to perform bimanual tasks in any form of work is sufficient to demonstrate total disability under the "any occupation" of the Plan, the particular wording of the statement fully undercuts DiGregorio's contention that the letter is evidence that she in

fact had such a disability. The letter states that she is disabled as to her own occupation as a secretary but states merely that DiGregorio believed she could not perform any bimanual tasks in any form of work. In her memorandum in support of her motion for judgment on the administrative record, DiGregorio states the following:

> By Dr. Jupiter's reporting of subjective limitations of bimanual tasks, he has effectively endorsed Ms. DiGregorio's complaints. Although his limitation in this regard is awkwardly transcribed, had he not believed that Plaintiff's subjective complaints of a limitation of bimanual tasks was supported by his objective findings on exam and by way of EMG/NCS testing, it is doubtful that he would have included them in the narrative.

Plaintiff's Memorandum in Support of Her Motion for Judgment on the Administrative Record, at 11 (citations omitted). I disagree. I do not find Dr. Jupiter endorsed such a view; indeed, the phrasing suggests he did not. In any event, the statement certainly is not affirmative evidence that Dr. Jupiter believed that DiGregorio was disabled as to any occupation.

Dr. Jupiter's December 5, 2001 responses do nothing to displace this conclusion. They lend further support to Hartford's position that DiGregorio was not totally disabled, by indicating Dr. Jupiter's agreement with Dr. Howard's restrictions. As DiGregorio points out, Dr. Jupiter submitted terse responses to the specific questions posed to him by Wilkins, and his responses thus are not inconsistent with the opinion that further restrictions were necessary. But the fact remains that Dr. Jupiter did not, in the responses or elsewhere,

indicate that he thought further restrictions were necessary or, more to the point, that DiGregorio was totally disabled as to any occupation.

In this connection, I find Hartford proceeded appropriately when it had Wilkins review Hartford's internal records prior to her correspondence with Dr. Jupiter. Upon review of DiGregorio's claim file, Wilkins noted that the prior EMG testing (and possibly the November 2000 test) indicated only mild nerve dysfunction and that two of DiGregorio's prior physicians had noted that her symptoms were not classical for carpal tunnel syndrome. Wilkins concluded that Dr. Howard's assessment appeared to be correct, and she apparently sought Dr. Jupiter's responses to confirm her view.

DiGregorio's attempts to align this case with Cook v. Liberty Life Assurance Co. of Boston, 320 F.3d 11 (1st Cir. 2003), are misplaced. In Cook, the court overturned defendant's denial of plaintiff's benefits because the decision was not supported by any medical evidence:

> In pursuing her appeal with Liberty, Cook provided the same type of evidence that she had always proffered to prove her claim--Dr. Blackwood's medical opinion, backed up by his chart notes. These documents were the only medical documents in Cook's file. Cook had been receiving disability benefits since May 1995, including under the "any occupation" definition of disabled since May 1997.

Id. at 23. Here, in contrast, DiGregorio's file contained the opinions of both Dr. Howard and Wilkins, who indicated that DiGregorio, while partially disabled, was not disabled as to any occupation. Indeed, the Cook court stated that "[t]hese

deficiencies in record support would not be so consequential if Liberty had developed any contradictory medical evidence in the record to support its decision to reject Cook's evidence." Id. Cook, to be sure, was a case involving a deferential standard of review, and thus the mere existence of contradictory evidence might not suffice to uphold Hartford's decision in this case. But given DiGregorio's underlying failure to adduce any affirmative evidence supporting her contention that she was disabled as to any occupation, the opinions of Dr. Howard and Dr. Jupiter are fatal to DiGregorio's claim. Accordingly, I conclude that Hartford's correctly determined that DiGregorio was not entitled to continued LTD benefits.[25]

2. Full and Fair Review

As a final matter, DiGregorio contends that she was denied a full and fair review as required by § 503 of ERISA, 29 U.S.C. 1133. Under the statute, "every employee benefit plan shall . . . afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). DiGregorio argues that because Hartford refused to provide her with her complete internal claim file, as opposed to the primary items Hartford relied on in denying her claim, it violated her rights under § 503(2).

[25]Because I conclude that DiGregorio was not totally disabled under the "any occupation" provision of the Plan, I do not reach the issue of whether she met the Plan's requirement that she be under the "regular care" of a physician.

Even assuming DiGregorio is correct that she was entitled to her complete file under § 503,[26] she must additionally demonstrate that she was somehow prejudiced by Hartford's failure to provide the file. See Terry, 145 F.3d at 39. She has not made such a demonstration.

In its multiple correspondences with DiGregorio, Hartford made clear that its primary bases for denying her claim were Dr. Howard's letter and Polman's employability analysis. It further

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[26]Hartford, however, likely satisfied the requirements of § 503 given the prevailing regulations at the time.

To be sure, the now current regulations accompanying § 503 provide that:

> the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures--
>
> . . .
>
> (iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

29 C.F.R. § 2560.503-1(h)(1). And the definition of "relevant" provided in paragraph (m)(8) of the current regulations includes, inter alia, information "submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination." Id. § 2560.503-1(m)(8). Thus, under the current regulations, a claimant such as DiGregorio would be entitled to much, if not all, of her claim file--in any event, she would certainly have been entitled to receive more than the several documents Hartford provided her before this litigation commenced.

However, the regulations accompanying § 503 at the time of Hartford's denial of DiGregorio's LTD benefits did not contain such broad requirements. Rather, they required only that a claimant denied benefits be provided "pertinent documents." 29 C.F.R. § 2560.503-1(g)(1)(ii). Thus, under the more narrow requirements, Hartford likely satisfied its duty under § 503 by providing to DiGregorio the documents it specifically relied on in deciding to deny her claim.

notified DiGregorio that in order to continue to receive her LTD benefits, she would have to provide further evidence of her continued disability.

DiGregorio contends that she was prejudiced because had she been provided with her complete file, she would have supplemented it with further evidence to support her claim.[27] This argument is post hoc rationalization. If DiGregorio had additional information that could have altered Hartford's decision, there was no reason she could not have submitted it along with the evidence she submitted during the appeals process. The implication that she did not submit such information because she assumed that Hartford had itself obtained the information is not persuasive. In this connection I note she has not alluded to any evidence that she had or has additional information that would have changed Hartford's decision to deny her claim. See Terry, 145 F.3d at 39 (§ 503 claim failed where plaintiff "has not presented any evidence that implies that a different outcome would have resulted"). Thus, I conclude that she was not denied a full and fair review of her claim.

III. CONCLUSION

For the reasons set forth more fully above, the clerk is directed to enter judgment for the defendants.

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[27]For instance, she contends that she would have provided evidence that she was under the regular care of a physician, evidence that she suffered from pain and other psychological deficits associated with her condition, and some further vocational expertise as to available jobs.

/s/ Douglas P. Woodlock

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DOUGLAS P. WOODLOCK
UNITED STATES DISTRICT JUDGE